C. Bed Hold Days Payment

A facility will be paid its per diem rate for the allowed bed hold days. For purposes of calculating the case mix average of the facility, residents on allowable leave will be classified at the default category (BC1) case mix weight.

CHAPTER 3

RATE COMPUTATION - NURSING FACILITIES

3-1 Rate Computation - Nursing Facilities - General Principles

It is the intent of the Division of Medicaid to reimburse nursing facilities a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care and care related costs greater than 90% of the median and less than the maximum rate, administrative and operating costs of less than the maximum rate, property costs that do not require a payment of the hold harmless provision and an occupancy rate of 80% or more.

3-2 Resident Assessments

All nursing facilities shall complete a Minimum Data Set 2.0, including sections S, T, and U (MDS) form on all residents, in accordance with the policies adopted by the Division of Medicaid, Case Mix Office and meet the scheduling criteria outlined in the MDS manual.

A. Submission of MDS Forms. Assessments of all residents must be submitted to the Division of Medicaid, Case Mix Office electronically, and meet the scheduling criteria outlined in the MDS manual. Initial admission assessments must be completed within fourteen (14) days of admission; hospital return assessments must be completed within fourteen (14) days of readmission to the facility; significant change assessments must be completed within fourteen (14) days of determining that a significant change occurred; assessments made as a significant correction of a prior assessment must be completed within fourteen (14) days of determining that an error was made on the most recent assessment; quarterly assessments must be completed within ninety (90) days of the previous assessment reference date; and annual assessments must be completed within 365 days of the last comprehensive assessment. Electronically submitted MDS data must meet the criteria for submission as adopted by the Division of Medicaid, Case Mix Office.

Completed assessments must be submitted to the Division of Medicaid, Case Mix Office on a bi-weekly basis.

Data processing on all assessments started within a calendar quarter will be closed on the fifth (5th) day of the second (2nd) month following the quarter, e.g., the MDS's with start

dates between July 1, 1996 and September 30, 1996 will be closed out for the final calculations on November 5, 1996. This allows a full month for the submission and correction of all MDS's begun in a calendar quarter. Assessments for a specific quarter which are received after the file has been closed will not be entered for previous quarterly calculations but will be reflected in subsequent quarterly calculations and in the annual report.

The submission schedule may be extended based on policy decisions made by the Division of Medicaid. This will include the dates of submission following the end of a calendar quarter and the use of assessments received after the cut-off date.

B. Assessments Used to Compute a Facility's Average Case Mix Score.

A maximum of three (3) assessments per resident per calendar quarter will be used to compute the quarterly case mix average for a facility. These will include the last assessment from the previous calendar quarter, and the first two assessments for the current calendar quarter. Therapeutic leave, hospital leave and bed hold days will be calculated

using the default category weight (Category BC1). Assessments used in the computation will affect the case mix computation using the start date of the assessment except for new admissions and readmissions. The computation of the facility's case mix score will use the date of admission for new admissions or residents that are readmitted after a discharge from the facility. In computing a facility's average case mix, the dates of admission or readmission will be counted and the dates of discharge will not be counted in the computation.

C. Audits of the MDS. The accuracy of the MDS will be verified by Registered Nurses. Beginning May 1, 1994, the review nurses will select a sample of the facility's residents. At least ten percent (10%) of the residents in the facility will be selected for the sample. The sample should include at least one resident from each major classification group. Residents may be added to the minimum sample as deemed appropriate by the review nurse(s) and/or other case mix staff. The sample will not be limited to Title XIX recipients since the total case mix of the facility will be used in computing the per diem rate. If more than twenty-five percent (25%) of the sample assessments are found to have errors which change the classification of the resident, the sample will be expanded.

Policies adopted by the Division of Medicaid and the Mississippi Case Mix Advisory Committee will be used as a basis for changes in audits of the MDS, the sample selection process, and the acceptable error rate. If MDS data is not available, the Division may temporarily cease performing audits.

D. Roster Reports and Bed Hold Reports.

Roster Reports are sent to all facilities on a monthly basis. Roster Reports should be checked by the facilities to determine if all assessments completed by the facility have been entered into the Division of Medicaid case mix database and if all discharge dates are reflected on the report. Missing assessments and discharge dates should be submitted electronically before the due date listed on the report. If the due date is on a weekend or a State of Mississippi holiday or a federal holiday, the data should be submitted on or before the first business day following such weekend or holiday.

Final quarterly Roster Reports will be sent to facilities with the quarterly rates. Even though it is too late to submit data to affect a closed quarter, any missing assessments or discharge dates should be submitted electronically in order to be reflected on the next quarter's Roster Report.

Bed Hold Reports should be reviewed by the facility to determine if all hospital and home/therapeutic leave has been properly reported. Corrections to bed hold days should be submitted to the Division of Medicaid, Case Mix Office by electronically submitting Section S of the MDS.

E. MDS Forms Which Can Not Be Classified. Should a facility submit an assessment that can not be classified into any of the Multi-State Medicare/Medicaid Payment Index (M^3PI) categories due to omissions of data or errors, the MDS form will be classified in the default case mix category of BC1. This category is the equivalent to the lowest case mix classification.

F. Failure to Submit MDS Forms. Nursing facilities that do not submit MDS forms will have the residents for which an assessment was not submitted classified in the default category of BC1, equivalent to the lowest case mix category until the next assessment is received. Delinquent assessments will result in the calculation of delinquent days at the default classification of BC1. Delinquent assessments are defined as those assessments not completed according to the

schedule required by the Division of Medicaid.

3-3 Resident Classification System

The Division of Medicaid will use the M^{3}PI to classify nursing home residents so a facility case mix average may be computed. This classification system utilizes specific items from the MDS to assign residents to categories which reflect the resident's functional status as well as resource utilization to meet resident care needs. The M^{3}PI contains thirty-four (34) total groups and is based on a descending hierarchical order ranging from most resource intense to least resource intense. (The graphic depiction of the classification hierarchy included at the end of this section provides a visual representation of this narrative).

For nursing facility rates established for dates of service on or after January 1, 1999, the Division shall utilize version 5.12 of the Mississippi M^{3}PI. Version 5.12 of the Mississippi M^{3}PI uses the same grouper methodology as the HCFA version 5.12 of the RUGS-III classification system with the 34 group logic.

The seven (7) major categories in which a resident may be classified are as follows:

Extensive Services

Rehabilitation

Special Care

Clinically Complex

Impaired Cognition

Behavioral Problems

Reduced Physical Functioning

These seven (7) major categories split out into additional classifications based on specific criteria; namely Activities of Daily Living (ADL) Index, Depression, and Nursing Rehabilitation, each of which is described below.

ADL Index

The ADL Index is a composite score for assessing the ability of a resident to perform in four of the Activities of Daily Living - bed mobility, toilet use, transfer, and eating, as defined in the MDS manual. The ADL Index is **NOT** a total of the actual ADL scores on the MDS. A value is assigned to show how a resident is scored for ADL performance in the following manner: